RESET

Medical Insurance Application

YOUR DUTY OF DISCLOSURE
It is a requirement by law that you disclose to BSP Health, every relevant risk or matter which you know or are reasonably expected to know which is relevant to BSP Health's decision to accept the risk of insurance and, if so on what terms. If you fail to comply with your duty of disclosure or your non-disclosure is fraudulent, BSP Health may void your contract of insurance at any time from inception or commence legal action against you. If your non-disclosure is innocent, BSP Health may choose not to void the contract and reduce any claim you make to the amount that would place it in the position it would have been in if the non-disclosure had not occurred. This application form is not a contract of insurance but it does form the basis of the contract of insurance. The general terms and conditions of the Policy is available upon request.

Insurance Advisor: _____ **QR:** _____

Quality Rating: _____ **Application No:** _____ **Quote No:** _____ **Life ID Number:** _____

SECTION A. PROPOSED POLICY OWNER

(To be completed by the Proposed Policy Owner)

1. Personal Details

Title	First Name	Middle Name(s)	Surname
Gender: ☐ M ☐ F	Date of Birth	Citizenship/Residency: ☐ Fiji Citizen and living in Fiji ☐ Fiji Citizen but not living in Fiji ☐ Non-Fiji citizen	

Have you, your family members or close associates been entrusted with any prominent public function in Fiji or another country, such as Head of State, Cabinet Minister, Member of Parliament, senior official of a political party, senior government, judicial or military official, senior executive of a state-owned corporation, Permanent Secretary, Department Head OR are you in a senior management position in any international organisation, such as Director, Deputy Director or Board Member? ► Yes ☐ No ☐ *If Yes, please provide details.*

2. Identification Document Details *(Complete the following for verification of identity)*

Type:	ID Number:	Expiry Date:
Type:	ID Number:	Expiry Date:
What is your Secret Question:		
What is the answer to your Secret Question?		

3. Contact Details *(Complete where relevant. At least one number is required)*

Home Number:	Work Number:	Mobile Number:

Preferred Communication Method

If you provide an email address, you will be sent a link to BSP Life's Customer Self Service Portal where you can access your Policy details and copies of our communication to you, including a copy of your Policy document. Requests for a hard copy of your Policy document must be made in writing or in person.

Email Address:	Alternate Email Address:
Postal Address:	
Physical Address: *(If not the same as the above)*	

4. Proposed Policy Owner Bank Account Details

Benefit Payments and Premium Refunds (if any) will be paid to this account

Bank Name:	Bank Account Number:	Bank Account Name:

SECTION B. GROUP DETAILS

(To be completed by the Insurance Advisor)

Group Name:	Employee ID Number:

SECTION C. COVER DETAILS

(To be completed by the Insurance Advisor)

Base Product	Rider(s)
Other(s)	

Initial _____

SECTION D. SPOUSE AND DEPENDENTS

Insured	First Name	Middle Name	Last Name	Date of Birth	Gender	* Relationship to Proposed Policy Owner	Residential status in Fiji
2							
3							
4							
5							
6							
7							
8							
9							

* Please specify whether de-facto or spouse.

SECTION E. GENERAL DETAILS

(To be completed by the Primary Life to be Insured)

1. Are you married or have been in a de-facto relationship for more than 2 years? Yes ☐ No ☐
2. Provide the following details of your current main occupation.

Type (e.g. clerk, police officer, miner, etc.)	Years of Employment	Industry (e.g. tourism, banking, etc.)

3. Have you, your spouse or any listed dependents had any medical or life insurance application declined, deferred, or accepted on special terms? Yes ☐ No ☐ ► *If Yes, please provide details.*

SECTION F. MEDICAL DETAILS

1. Height and Weight

Insured	Height (cm)	Weight (kg)	If your weight has changed by more than 20kgs in the last 12 months please indicate below	Please state reason for change(s)
1			Increase ◯ Decrease ◯	
2			Increase ◯ Decrease ◯	
3			Increase ◯ Decrease ◯	
4			Increase ◯ Decrease ◯	
5			Increase ◯ Decrease ◯	
6			Increase ◯ Decrease ◯	
7			Increase ◯ Decrease ◯	
8			Increase ◯ Decrease ◯	
9			Increase ◯ Decrease ◯	

2. Have you, your spouse and any of your listed dependents, resided overseas within the last 5 years? Yes ☐ No ☐

► *If yes, please provide the following details in relation to your previous country of residence:*

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	For how long did you visit this Medical Attendant,General Practitioner or Clinic

3. Have you, your spouse or any listed dependents ever had any other medical insurance prior to applying to BSP Health? Yes ☐ No ☐

► *If yes, please provide details:*

Initial _____

4. Do you, your spouse or any of your listed dependents currently have policies with any other health insurance scheme? Yes ☐ No ☐

► *If yes, please provide details:*

5. What is your spouse or any listed dependents usual Medical Attendant, General Practitioner or Clinic?

Name of Medical Attendant, General Practitioner or Clinic	Telephone Number	Postal/Email Address	For how long did you visit this Medical Attendant,General Practitioner or Clinic

SECTION G. HEALTH DECLARATION

(To be completed by the Primary Life to be Insured)

You **MUST** disclose details of any Existing Medical Conditions. Existing Medical Condition means:

(i) any chronic or ongoing (whether arising from a chronic Condition or otherwise) medical or dental Condition, Injury, Illness of which the Insured is aware or should reasonably have been aware, whether or not it is medically documented or under investigation prior to applying for insurance with BSP Life, or

(ii) any physical or mental Illness or medical Condition (including pregnancy), defect, injury, illness of which the Insured is aware or should reasonably have been aware of or for which treatment, medication, preventative medication, advice, preventative advice or investigation has been received prior to applying for insurance with BSP Life whether disclosed or not and where any symptom is the subject of an investigation, that symptom or Condition falls within this definition, regardless of whether or not a diagnosis has been made.

1. Have you, your spouse or any of your listed dependents ever suffered from or ever been diagnosed with, had or been advised to have surgery or medical treatment of any sort whatsoever or ever had or are currently experiencing symptoms or receiving treatment for any Existing Medical Condition as described above? Yes ◯ No ◯ ► *If Yes, please provide full details:*

2. Have you, your spouse or any of your listed dependents ever suffered from or ever been diagnosed with, had or been advised to have surgery or medical treatment of any sort whatsoever or ever had or are currently experiencing symptoms or receiving treatment for any of the following conditions?

(a) High blood pressure, low blood pressure, chest pain, heart attack, rheumatic fever/heart disease or any other heart related condition or diseases — Yes ◯ No ◯

(b) Leukaemia, haemophilia, anaemia or any other form of blood and circulatory disorders. — Yes ◯ No ◯

(c) Brain or nervous disorders, multiple sclerosis, tremors, numbness, migraine, giddiness, fits of any kind, paralysis, fainting episodes, depression or any type of mental disorders, or epilepsy. — Yes ◯ No ◯

(d) Asthma, bronchitis, tuberculosis, coughing of blood, shortness of breath or any other disorders of the respiratory system, or pleurisy or emphysema. — Yes ◯ No ◯

(e) Stomach, intestinal, colon or rectal disorders, ulcer, piles, hernia, gall bladder stones, liver and any other form of gastrointestinal tract disorders, or the passing of blood. — Yes ◯ No ◯

(f) Kidney, bladder or prostate diseases, including renal colic and stone, urinary tract infection and passing of blood in the urine. — Yes ◯ No ◯

(g) Gout, arthritis, rheumatism, cartilage or ligament injury, bone fracture or any other form of muscular - skeletal disorders, disc lesion, or other back trouble including lumbago, fibrositis, sciatica or whiplash injury. — Yes ◯ No ◯

(h) Defect in sight, hearing and speech or any other physical deformity or abnormality of the eyes, ears, nose and throat. — Yes ◯ No ◯

(i) Diabetes or pancreatic diseases, abnormal blood sugar level, liver diseases or hepatitis thyroid or any hormonal disorders. — Yes ◯ No ◯

(j) Cancer, tumour, cyst or growth of any type whether it be benign or malignant. — Yes ◯ No ◯

(k) Skin disorder(s) of any type for example, dermatitis, eczema, psoriasis, skin lesion or melanoma. — Yes ◯ No ◯

(l) Sexually transmitted infections including syphilis, gonorrhea, herpes, warts, hepatitis and acquired immune deficiency syndrome (AIDS) or AIDS related conditions and antibodies. — Yes ◯ No ◯

(m) Night sweats, inexplicable weight loss, persistent fever, diarrhea or swollen glands. — Yes ◯ No ◯

Initial _____

(n) **Males Only** - Prostate condition, increased urinary frequency, problems passing urine, blood in the urine, disease or disorder of the testicles, bladder and urethra. Yes ◯ No ◯

(o) **Females Only** - Abnormal cervical smear, abnormal mammogram, endometriosis, pelvic examinations, irregular, heavy or painful menstrual cycles, miscarriages, pregnancy complications, prolapse or bladder problems Yes ◯ No ◯

(p) **Females Only** - Abnormal cervical smear, abnormal mammogram, Are you pregnant? Yes ◯ No ◯

► *If Yes, please provide the expected date of delivery.* _____ / _____ / 20 _____

(q) Any other illnesses, injury, operation, disability or physical abnormality. Yes ◯ No ◯

3. Have you, your spouse or any of your listed dependents ever been refused as a blood donor, or had any blood test or oth testing services or ever received a blood transfusion, treatment with human blood products or an organ transplant?

Yes ☐ No ☐ ► *If Yes, please provide the following details:*

Date	Service Refused/ Treatment Received	Name of Medical Attendant, General Practitioner or Clinic	Postal/Email Address	Reason(s)

4. Have you, your spouse or any of your listed dependents during the past 5 years have you consulted any medical professional or clinic or had any medical examination, advice, treatment, surgical operation, x-ray, ECG, computerised tomography (CT) scan, magnetic resonance imaging (MRI) or any other test, treatment or investigation not disclosed in the Health Declaration Questions

Yes ☐ No ☐ ► *If Yes, please provide the following details:*

Date	Medical Service	Name of Medical Attendant, General Practitioner or Clinic	Postal/Email Address	Reason(s) for Consultation

5. Have your spouse, any of your parents, brothers or sisters died or suffered from heart disease including cardiomyopathy, stroke, high blood pressure, diabetes, kidney disease, polycystic kidney disease, cystic fibrosis, cancer, mental disorder, muscular dystrophy or have any of your sexual Partners suffered or died from tuberculosis, hepatitis, AIDS or AIDS related conditions?

Yes ☐ No ☐ ► *If Yes, please provide the following details:*

Name of Family Member	Relationship to Primary Life to be Insured	Medical Condition	Age at Diagnosis	Age at Death *(if applicable)*

6. Have you, your spouse or any listed dependents in the last 2 years smoked tobacco or used any other narcotic substance, consumed kava, alcohol or any other non-prescribed drugs or intoxicants?

Yes ☐ No ☐ ► *If Yes, please provide the following details:*

Measurement				Smoker Status		Has your weight changed by more than (+/-) 20kgs in the last 12 months?
Height	cm	Weight	kg	Yes ☐	No ☐	Yes ☐ No ☐ ► *If Yes, please provide the following details:*
Change in weight				Change in kgs		Reason(s) for change
Increase ☐		Decrease ☐				

Have you in the last 2 years used or consumed any of the following?

Tobacco Consumption		**Narcotics Consumption**		**Alcohol Consumption**		**Consumption of Kava**		**Consumption of non-prescribed drugs / intoxicants**	
Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
(# per day)		(# or litres per day)		(litres per day)		(litres per day)		(# or litres per day)	

SECTION H. PROVIDERS

(Only provide this information if Outpatient Care Plus is a selected Rider)

Nominated Doctor:	
Nominated Pharmacy:	

Initial _____

SECTION I. NOMINATION OF BENEFICIARIES

The nomination of beneficiaries applies if the Proposed Policy Owner is also the Primary Life to be Insured. It only applies to the Funeral Assistance Benefit. Only Spouse/Primary Insured above 18 Years old

Name	Contact Details	Relationship to Policy Owner	Date of Birth	Beneficiary Allocation %
Total				

SECTION J. PREMIUM PAYMENT DETAILS

(To be completed by the Proposed Policy Owner)

Salary Deduction: ◯ Weekly ◯ Fortnightly ◯ Monthly

What is the Payer's Name?

What is the Payer's telephone number or email address?

What is the Payer's EDP / Salary Number?

Direct Deduction: ◯ Quarterly ◯ Semi-annual ◯ Annual

If payment is from a Bank, provide the following details in relation to the bank account from which premium payments will be made and complete the relevant Bank Deduction form, if applicable. Otherwise, indicate if payment is via internet banking: Yes ◯ No ◯

Bank Name: | Bank Account Name: | Bank Account Number:

SECTION K. THIRD PARTY DECLARATION

(To be completed by a third party completing the form on behalf of the Proposed Policy Owner/Primary Life to be Insured)

I certify that: (a) the Proposed Policy Owner/Primary Life to be Insured was unable to fill this application form, (b) I have completed this application form using information given to Me by the Proposed Policy Owner/Primary Life to be Insured and (c) the information provided in this application form has been read back to the Proposed Policy Owner/Primary Life to be Insured and explained to him/her in the (Please specify language) _____ language and the Proposed Policy Owner/Primary Life to be Insured understood its contents.

Name: | Occupation:

Residential Address:

Telephone: (Home) | Work: | Mobile:

Signature: | Signed at: | Date:

Vetted and Endorsed by Business Relationship Manager:

Signature: | Signed at: | Date:

SECTION L. GENERAL DECLARATION

*(To be completed by the Primary **Life to be** Insured)*

I DECLARE THAT:

1. The information provided in this application is correct and that failing to disclose information to BSP Health may result in my Policy being cancelled from inception and/or legal action filed against me including recovery of any claims paid.

2. I understand that insurance cover under the Policy will not commence until BSP Health has accepted this application (subject to underwriting terms) and received premium.

3. I consent to:
a. and authorise BSP Health, its employees and agents to

i. collect and use personal information in this application form or from external parties to assess this application and provide services. External parties include reinsurers, employers, providers (medical and pharmaceutical) or any other person or entity that holds or requires information relevant to this application or the assessment of any claim.

ii. Store the information in this application or obtained pursuant to (a) above at BSP Health's head office at BSP Life Centre, Suva, Fiji and by any of its data storage or software service providers (whether in Fiji or elsewhere) in compliance with its Privacy Policy and Fiji law.

b. email communication with BSP Health regarding this application and if accepted, my policy, and I will maintain proper software to securely access email communication from BSP Health. I will promptly inform BSP Health of any changes to information in this application including changes to my health status prior to Policy commencement or BSP Health accepting this application.

c. my contact information being disclosed to BSP Health's related entities or contractors for market research on BSP Health products and services or to market other products to me unless I request otherwise in writing.

Full Name of Primary Life to be Insured

Signature/Thumb Print | Signed at | Date

Full Name of Witness

Signature/Thumb Print | Signed at | Date